CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services

Ernie Fletcher
Governor

275 E. Main Street, 6W-B
Frankfort, KY 40621
(502) 564-7540
Fax: (502) 564-0249
www.chfs.ky.gov

Tom Emberton, Jr.
Secretary

Shawn M. Crouch
Commissioner

December 12, 2007

**TO: Home Health (34) Providers**
**Provider Letter A-110**

**RE: Changes to DMS Home Health PA Form effective 1/1/08; and**
**Additional Program Information**

Dear *KyHealth Choices* Provider:

This letter is to inform you of updates located on the Department for Medicaid Services (DMS) website for Home Health care, http://chfs.ky.gov/dms. These changes include:

- A revised Home Health (HH) Prior Authorization (PA) FAX form with instructions for completion (enclosed);
- A list of medical supplies/supplements that are appropriate for HH Medicaid patient care; and
- A list of supplies (not all-inclusive) considered by DMS to be an administrative cost to the HH agencies that are not reimbursable by DMS.

First - a revised Prior Authorization (PA) FAX form for the Kentucky Medicaid HH Care Services Program has been developed. Effective 1/1/08 providers must use the newly revised PA FAX form (MAP-130) when requesting home health care services and/or supplies/supplements from SHPS. The revision date on this form is 1/1/2008. **NOTE: The MAP-130 PA FAX form is a two-page document.** The MAP-130 also has two pages of instructions for correct completion of the form. Providers should destroy all copies of the previous versions of the PA FAX form. SHPS will not process PA requests from previous versions beginning 1/1/08. SHPS has been instructed by the DMS not to process any PA FAX forms submitted that are illegible, incomplete or are not a clean submission. An electronic version of the revised FAX form with accompanying instructions for completion of the form (two pages each) can be obtained by logging onto the DMS web-site at http://chfs.ky.gov/dms. After the DMS website is accessed, click on "Covered Services", then scroll down to click on "Home Health Services" and then click on "Forms" to download a copy of the revised PA FAX form.

**DMS and SHPS strongly encourage HH providers to submit the hard-copy MAP-130 PA FAX form for PA reauthorizations, modifications to existing plans (one day prior to any additional visits/supplies), and therapy requests (post evaluation). This ensures that HH providers have documentation of the services/supplies/supplements requested. It also frees SHPS reviewers to receive PA call-in requests for new patients, therapy evaluations, MSW evaluations, PRN visits and questions from providers concerning the "unreviewed" status of the previous day's PA requests from the Daily Activity Report (DAR).**

**(Please see reverse side)**

**Providers must review the DAR upon receipt and notify SHPS within 48 hours if any information on the DAR is incorrect. DMS suggests that for all call-in requests, providers should have the appropriate information and documentation needed for PA approval before contacting SHPS.**

Second, - A schedule of appropriate medical supplies/supplemental nutritional products used in the HH Care program has been developed by Medicaid and is available on the DMS website for quick reference by providers. The Health Care Procedure Coding System (HCPCS) National Level II Medicare Codes manual should be the primary source of information for HCPCS units and descriptions requested on Prior Authorizations (PA) and on claims submitted for payment. **NOTE: The Disposable Medical Supplies & Nutritional Products list distributed with HH Services Provider letter #A-100 dated June 29, 2005, is obsolete and should no longer be used.** If a HCPCS code is not available on the HH Care Supply schedule, providers should reference the Durable Medical Equipment (DME) supply/fee schedule to determine if the necessary supply is available through the DME program and follow the procedures necessary for DME approval. DME suppliers are also a good source of information for appropriate HCPCS codes. If a required supply is not on the HH Care supply schedule or the DME supply/fee schedule, then approval may be granted on a case by case basis based on documentation and determination of medical necessity, and will be reimbursed at invoice plus twenty percent. If the required supply is not in the HCPCS manual, on the DMS HH Care supply schedule or the DME supply/fee schedule, providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) at 877-735-1326 for the correct HCPCS code. Implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of HCPCS codes for transactions involving health care information for Medicare, Medicaid, and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner

One common concern voiced by providers is how to calculate the request for and reimbursement of tape per unit. If the tape is a non-routine supply, it will be reimbursed at the rate of 18 square inches per one unit (as identified in the HCPCS manual). For example, if a roll of tape has a total of 144 square inches, then divide 144 by 18 to determine that one roll of tape contains eight (8) units.

Finally, effective 1/1/08, the DMS website will have an Administrative Home Health Care supply list for HH providers to identify common supplies (not all-inclusive) used in the HH program that are not reimbursable by Medicaid.

As always, DMS appreciates the continuing service you provide to the Medicaid members of the Commonwealth. If you have questions regarding this letter or need additional clarification, please contact Betty Murphy, MSS III, or Ellenore Callan, RN, NCI, at (502)564-5560 or via email at Betty.Murphy@ky.gov or EllenoreC.Callan@ky.gov.

Sincerely,

Carrie Banahan
Deputy Commissioner

Xc: Home Health (34) Provider Letter Number A-110

SMC/CB/amd00365

MAP-130

# PRIOR AUTHORIZATION FAX-FORM
## Kentucky Medicaid Home Health Care Services Program
## FAX NUMBER: 1-800-664-5749 CALL IN: 1-800-664-5725
## DATE FORM COMPLETED____/____/_____

TYPE OR PRINT CLEARLY IN DARK INK ONLY. COMPLETE ALL QUESTIONS. CLEAN FORM REQUIRED FOR EACH SUBMISSION. ILLEGIBLE AND INCOMPLETE FORMS WILL BE UNPROCESSED.

SUPPLY ONLY_____ NEW PATIENT_____ RE-AUTHORIZATION_____ MODIFICATION_____

**Start Date on Plan of Care: ____/____/_____ Date CMS 485 completed: ____/___/_____**

PATIENT INFORMATION: NAME: _____
Last First MI

ADDRESS: _____
Street City/State zip county

TELEPHONE: _____ Height/Weight_____ DATE of BIRTH: ___/___/____

IF UNDER AGE 21, EPSDT SERVICES RECEIVED? _____Y _____N

GENDER: M____ F____ KYHEALTH CHOICES IDENTIFICATION NUMBER:_____

IS PATIENT HOMEBOUND DUE TO MEDICAL CONDITION: _____Y _____N if no, explain justification for HH services in lieu of outpatient services _____

_____

DATE RECIPIENT LAST SEEN BY THE PRIMARY PHYSICIAN _____/_____/_____

PRIMARY Dx(s) _____
ICD-9-CM code and description Onset Date

SECONDARY Dx(s)_____
ICD-9-CM code and description Onset Date

IS THERE A WILLING AND RELIABLE CAREGIVER _____Y _____N if no, please explain _____

_____

HAS RECIPIENT BEEN DISCHARGED? _____Y _____N DATE OF DISCHARGE ___/___/_____

DISCHARGE REASON _____

IS RECIPIENT A RESIDENT OF A PERSONAL CARE HOME (PCH)? _____Y _____N

IF YES, NAME AND ADDRESS OF THE PCH _____

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PRIMARY PHYSICIAN INFORMATION: NAME: _____

ADDRESS_____

PHYSICIAN'S UPIN_____ PHYSICIAN'S TELEPHONE # _____

PHYSICIAN SIGNED ORDER FOR THE REQUESTED SERVICES AND/OR SUPPLIES? _____Y _____N

AGENCY INFORMATION: NAME _____(Branch) _____

ADDRESS _____

REQUESTOR'S NAME_____ CONTACT (if different) _____

TELEPHONE # _____ FAX # _____ PROVIDER # _____

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RECIPIENT NAME: _____ KYHEALTH CHOICES ID #: _____

**HH Care Services**

| Revenue Code | Type of Service, Frequency and Expected Duration | # Visits Requested | Start Date | End Date |
|---|---|---|---|---|
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**WOUND CARE:** DISCRIPTION_____ LOCATION _____

LENGTH _____ DEPTH _____WIDTH _____ CIRCUMFRENCE_____ DECUBITIS ____Y ____N STAGE_____

**PHYSICIAN'S WOUND TX ORDERS:** _____

**CLINICAL SUPPORTING DOCUMENTATION FOR GLOVES USED IN HH CARE:**

**CLINICAL SUPPORTING DOCUMENTATION FOR NUTRITIONAL SUPPLEMENTS:**

**CLINICAL SUPPORTING DOCUMENTATION FOR INCONTINENT SUPPLIES:**

**OTHER CLINICAL SUPPORTING DOCUMENTATION:**

**HH Care Disposable Medical Supplies-Revenue Code 270 and 279 Nutritional Supplements.**
**EXCLUDE ALL ADMINISTRATIVE SUPPLIES**

| Revenue Code | HCPCS Code | Item Description | Quantity/ Units | Start Date | End Date |
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MAP-130a

# PRIOR AUTHORIZATION (PA) FAX-FORM INSTRUCTIONS
## Kentucky Medicaid Home Health Care Services
## January 1, 2008

Indicate reason the PA request is being submitted.

Please list the start date of the recipient's plan of care and the date the CMS 485 Home Health Certification and Plan of Care was completed.

**Patient Information** – In this section, list all the pertinent personal information of the Home Health (HH) recipient.

**EPSDT** - If recipient is a child under age 21, services and supplies appropriate to the EPSDT program should be requested under EPSDT.

**Homebound Status** – Consideration of the recipient's medical and mental condition, functional limitations and degree of difficulty in accessing medical care, and the services to be provided, shall be considered to determine if it is reasonable to request Medicaid reimbursement for HH services. *Outpatient services, including physician office or clinic visits, should be utilized when the recipient is medically able to do so.*
**Explanation related to homebound status is not required for "supply only" recipients. The PA approval for "supply only" is ninety (90) days.**

Include the date last seen by the primary physician.

**Recipient Diagnosis** – It is imperative to list the recipient's pertinent primary and secondary diagnoses code, description and onset date. **List all diagnoses relative to the services and supplies requested.**

**Caregiver information** - If there is not a reliable caregiver, provide documentation for recipient self care and necessary HH intervention.

**If recipient has been discharged from your Home Health Agency (HHA), give date of discharge and reason.**

**Personal Care Home** (PCH) - If recipient is a resident of a PCH, give the name and address of the PCH. **Personal Care is not approved for PCH residents** (Revenue code 570).

**Primary Physician Information** – Complete the information for the physician who is responsible for medical care of the recipient. Include: primary physician name, address, UPIN, telephone number, and verify if the physician has signed an order for the requested services and/or supplies. (S*igned and dated physician order(s) required within 21 days of receiving order(s).*

**Agency Information** – List the HHA name, address, person in the agency requesting the PA, *and a contact name if different than the requestor,* telephone, fax and provider number.

**(Instructions continue on page 2)**

## Page 2 – Continuation

List the Home Health Care services you are requesting: explain the type, frequency, duration, number of visits, start and end date of the services.

**Wound care** – The Physician's order, as is written and a description of the wound(s) are required.

**Provide clinical supporting documentation and appropriate diagnoses to justify and validate "Medical Necessity" for all requests of gloves, nutritional supplements, and incontinent supplies.**

**Gloves – used for the protection of the caregiver are NOT to be authorized.**
**Approved coverage examples** (*not all inclusive)*: wound care, trach care, IV site care, in & out cath care, immune suppressed, (new or infected, g-tube, ileostomy, and colostomy site care within the first 60 day plan).

**Nutritional Supplements – must be part of the HH Plan of Care/Treatment which includes an approved HH service.** Nutritional supplements are covered for the following diagnoses and/or conditions-disorders of significant mental or physical health including trauma, significant weight loss, chronic and/or acute illness which have been determined to require nutritional supplements in order to maintain optimum health status and adequate weight.
**Approved coverage examples** (*not all inclusive)*: Cancer, Dyspnea related to moderate/severe Pulmonary or Cardiac Disease, Renal Failure, Dysphagia, Wounds, Burns, Alcohol Abuse, Substance Abuse, Gastrointestinal and/or Bowel Impairment, Mal-absorption Impairments, Failure to Thrive, Anorexia, Bulimia, and Hyperkinesis associated with diseases such as: Parkinson's disease, Huntington's chorea or Cerebral Palsy.
**Including, but not limited to, conditions- disorders:**
Abnormal labs, Albumin, Total iron binding capacity, Decreased appetite due to side effect of medication, Metabolic or Electrolyte Disorders, Psychological Disorders impairing food intake such as Depression.

**Total nutritional products must be requested through the DME program.**

**Incontinent supplies – The recipient must be greater than 36 months of age.**
A diagnosis of incontinence and a diagnosis related to incontinence are required. Also required is a description of the type of incontinence, i.e. Bladder &/or Bowel control problems, Stress, Overflow, Nocturia, Urinary urge and Urinary retention. **Each recipient's needs must be evaluated for type and quantity or combination of incontinent supplies.**

**Other Supporting Clinical Documentation** - List other pertinent information for recipient's care needs not detailed in any other category. HHA must **justify and validate "Medical Necessity"** for all requests.

**Disposable medical supplies and supplements** – List the medical supplies and supplements that are required to treat the recipient's illness/injury. **Exclude all administrative supplies.**